NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-03-1756-01

September 15, 2003

An independent review of the above-referenced case has been completed by a doctor board certified in family practice. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to___.

Notice of Independent Review Determination

CLINICAL HISTORY
This patient sustained a work related injury on ___. He received extensive and thorough evaluations and treatments including radiographs, MRI's, medications, physical therapy, work hardening program, a TENS unit, facet injections, nerve blocks, epidural steroid injections, discograms, and two surgeries: an ALIF on 8/11/98 and a PLIF in 2/2000. He saw multiple physicians, and unfortunately, continued to have severe pain in spite of all his treatments.

REQUESTED SERVICE(S)
Purchase of an inferential muscle stimulator.

DECISION
Uphold denial.

RATIONALE/BASIS FOR DECISION
This type of device is indicated for short term, adjunctive therapy for acute pain disorders. There is no accepted peer review literature to support using this device in chronic pain situations. Unfortunately, by the time the muscle stimulator was initiated in 10/2002, this patient was a chronic pain patient. Although there are some subjective notations the device helped somewhat, there is no objective documentation to show increase in function or a persistent decrease in pain with its use. Therefore, the muscle stimulator is not medically necessary for this patient with this chronic pain disorder.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 15th day of September 2003.